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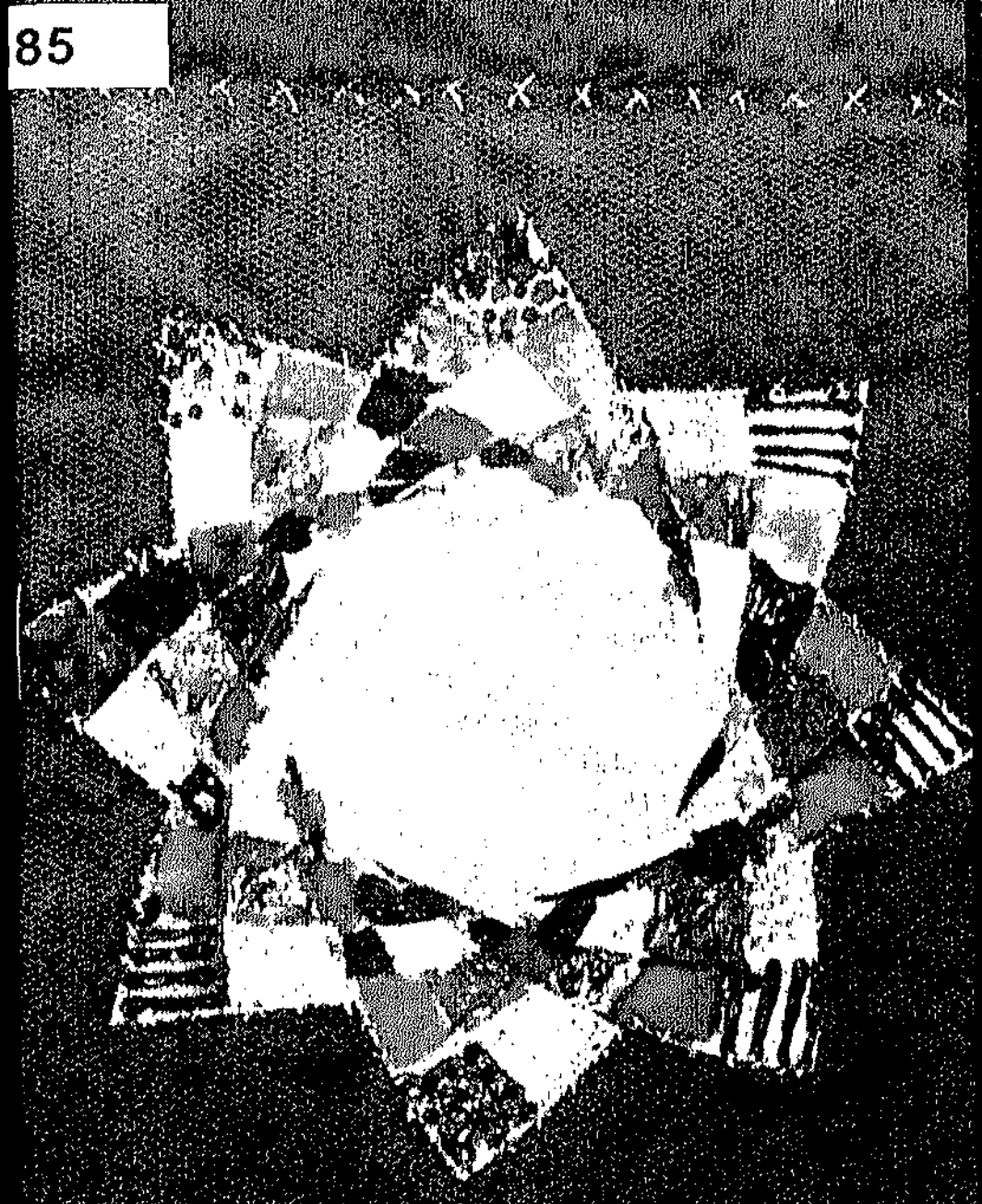

A Framework for Quality in Long-Term Residential Care for Older People in Ireland

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National Council on Ageing and Older People

A Framework for Quality in Long-Term Residential Care for Older People in Ireland

National Council on Ageing and Older People

Report No. 62

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Foreword

The National Council on Ageing and Older People has long been concerned about the quality of long-term residential care for older people in Ireland. In 1986, its predecessor, the National Council for the Aged published *"It's Our Home". The Quality of Life in Private and Voluntary Nursing Homes.*

In 1999 the Council commissioned a postal survey of all long-term residential care facilities in the country to determine:

- whether facilities had quality initiatives in operation;
- providers' views and aspirations for future provision of long-term care;
- providers' views on the introduction of a national quality monitoring policy.

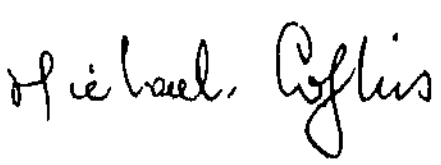
Additionally, consultations were conducted with medical professionals and health board personnel involved in the provision of services to older people in Ireland. Based on the findings from these investigations, the Council developed a framework for fostering quality in long-term residential care. The framework was considered and broadly endorsed at a seminar organised by the Council on 29 May 2000 to discuss issues of quality in long-term residential care.

In presenting this framework, the Council wishes to signal its concern at the lack of adequate provisions for the development of uniform quality standards in all long-term residential care facilities for older people provided by the private, voluntary and public sectors. It is confident that the framework it proposes will serve to promote an ethos of quality across all sectors, which will benefit both residents and those involved in the provision of residential care for older people. National quality standards must be introduced in all sectors, and designated funding must be provided to ensure their implementation. Otherwise the quality of care and the quality of life of older people in long-term residential care will be prejudiced in facilities which do not actively seek to ensure health gain and social gain for each of their residents.

I would like to thank particularly Ms Gail Birkbeck and Ms Christine Linehan from the National Research Agency for carrying out the above mentioned survey and consultations on the Council's behalf.

I also thank the members of the Council's Consultative Committee on Quality and Effectiveness in Long-term Residential Care for overseeing the study in a consultative capacity. The members of the Committee were Dr John Gibbon, Chairperson, Ms Evelyn Barry, Mr John Brady, Mr Eddie Collins-Hughes, Ms Janet Convery, Mr Jim Cousins, Dr Margo Wrigley, Ms Mary Nally, Mr Joe Stanley, Dr Niall Maguire, Dr Nuala O'Donnell, Ms Maura Hooper and Mr Pat O'Leary.

Finally, I thank Council staff for their assistance in developing the project and in preparing this report for publication. Our thanks are due to Mr Bob Carroll, Director for preparing the draft Framework for Quality in Long-term Residential Care, to Ms Catherine Conlon, Research Officer for drafting this report, and to Mr Eamonn Quinn, Resources Officer for arranging its publication.



Dr Michael Loftus
CHAIRMAN
December 2000

Contents

Chapter 1

Introduction

1. Introduction

This report is the outcome of a programme of work conducted by the National Council on Ageing and Older People on the quality of long-term residential care provision for older people in Ireland. The aim of the report is to provide a framework for developing quality in long-term residential care settings with a focus on the well-being, dignity and autonomy of older residents.

1.2 Quality in Long-Term Care

The issue of 'quality' in long-term residential care for older people has long been a concern for the National Council on Ageing and Older People. The Council sees long-term residential care as part of a continuum of care comprising a comprehensive range of services that meet the needs of the heterogeneous group of older people in our society. While it is stated policy that older people should be able to live at home for as long as possible, it is also acknowledged that long-term care continues to play an important role in the continuum of care services for older people. Older people who have a disability, who are frail or ill or who are unable to live at home due to the lack of formal and informal care resources, will continue to need long-term residential care. The quality of life of older people in long-term residential care should be the central objective of this component of services for older people.

The National Council for the Aged, the predecessor to the National Council on Ageing and Older People, commissioned research into the quality of life in private and voluntary nursing homes in the mid 1980s (O'Connor and Walsh, 1986). This study raised a number of issues and made recommendations that are still relevant a decade and a half later. The study concluded that there are two dimensions to quality in long-term care:

- Objective standards of care encompassing: The setting, buildings, facilities and staff arrangements which were described as indicators of the possible quality of life that can be afforded to residents.
- The context of care: How residents experience life in that setting.

Also, the study noted specific indicators of poor quality care including:

- a failure to meet the needs of residents,
- a failure to foster an environment that creates or maintains independence particularly for those who are sick or immobile,
- a failure to take initiatives to foster the potential or broaden the recreational experience of residents.

The report concluded that in the homes studied:

> The environment of the homes entails living a passive life in a public place. The quality of life needs to include the prevention of avoidable mental decline and the maintenance of physical and social function. The restoration of, or compensation for, loss of diminishing function is central to establishing the quality of life as the main theme of care.
> (O'Connor and Walsh 1986: 129)

1.3 Quality in Health Care Policy

Irish health policy as set out in the strategy document *Shaping a Healthier Future* (1994) is underpinned by the principles of equity, quality of service and accountability. The objective of health care as set out in the strategy is the achievement of health gain and social gain. According to *Shaping a Healthier Future* (1994):

- Health gain refers to improvements in the health status of the care recipient to bring about improvements in life expectancy or quality of life through cure or alleviation of illness or any other general improvement in the health of the individual.
- Social gain refers to broader aspects of quality of life for the care recipient.

While *Shaping a Healthier Future* (1994) does not elaborate on the concept of quality of life, the World Health Organisation defines quality of life as the individual's own perception of their position in life having regard to their value systems, goals, expectations, standards and concerns. Furthermore, they recognise that quality of life is affected by a person's physical health, psychological state, level of independence and salient features of their environment (Szabo,1996).

The National Council on Ageing and Older People has prepared this report to highlight the need of older people resident in long-term care settings to be cared for in such a way that they experience improvements in their physical and psychological health and that they feel that their quality of life is enhanced. In other words, it wishes to ensure residents experience health and social gain from the care they receive. Images of long-term care homes as institutions where older people live passive lives without any autonomy or independence do not sit well with all of our aspirations for a healthier old age for our older family relatives, friends and for ourselves. The rationale for developing a framework for quality standards in long-term care is to ensure that the principles of health care policy are implemented to the benefit of older people across the continuum of care.

1.4 Developing a Framework for Quality in Long-Term Care

To begin this process the Council commissioned research to assess the current situation on the application of quality standards in long-term residential care settings. A postal survey of all long-term care facilities in the country was undertaken to assess:

- whether facilities had quality initiatives in operation,
- the providers' views and aspirations for future provision of long-term care
- the providers' views on the introduction of a national quality monitoring policy.

As well as the survey, consultations were held with medical professionals and health board personnel involved in the provision of services to older people in Ireland.

The Council's intention was to involve all providers of long-term residential care as well as relevant health professionals and administrators in the process of developing quality in long-term residential care.

On the basis of the surveys findings, the Council developed a framework for fostering quality in long-term care.

A seminar attended by a broad range of interest groups including providers, administrators, planners and advocates was hosted by the Council on 29 May 2000 to discuss the research findings and the Council's proposed framework for promoting quality. The seminar provided an opportunity for a broad constituency to

discuss the issue of fostering quality care. A keynote address, presented by Dr Gillian Dalley, Director of the Centre for Policy on Ageing in the UK described the process of developing national minimum required standards for care homes in England and Wales. Dr Dalley's address is included in the appendices to provide an opportunity to view a case study on how this process has been conducted in another jurisdiction.

A Framework for Quality in Long-Term Residential Care for Older People in Ireland is divided into the following chapters:

Chapter 2 contains an overview of the development of long-term residential care in Ireland. This provides an understanding of the context in which this framework for developing quality in long-term residential care is being proposed.

Chapter 3 reports on research undertaken on behalf of the Council involving providers, medical professionals and health board administrators to assess the current situation regarding quality in long-term residential care.

Chapter 4 presents the framework for developing quality in long-term residential care proposed by the National Council on Ageing and Older People.

Chapter 5 reports on a seminar hosted by the Council entitled *'Fostering Quality in Long-Term Residential Care for Older People in Ireland'* on 29 May 2000.

Chapter 6 concludes the report by outlining conditions for the successful implementation of a policy on quality in long-term residential care.

Chapter 2

The Development of Long-Term Residential Care in Ireland

2.1 Early Provision of Long-Term Residential Care

In Ireland, public provision of long-term residential care dates from the early nineteenth century. At that time it was part of the Poor Law provisions that were initially directed at a mix of persons deemed to be destitute. Towards the end of the nineteenth century, a policy of specialised hospitals and homes was introduced and older people were accommodated in what were commonly known as County Homes. County Homes occupied buildings that had originally been constructed as workhouses. Some upgrading of these facilities occurred during the 1950s and 1960s and new accommodation was provided in some areas, increasing the overall number of long-term residential care places available. While these homes were intended to accommodate older people specifically, in practice lone mothers, children and people with an intellectual disability among others were also allocated places in the homes. At the same time, community care services for older people were completely undeveloped and it was left to voluntary organisations to provide care for people in the community.

2.2 *The Care of the Aged* Report and Long-Term Residential Care

In response to the poor standard of residential care and the absence of community care services for older people, an Inter-Departmental Committee on Care of the Elderly produced *The Care of the Aged* report in 1968. This provided the blueprint for public policy for the next twenty years. The central component of this policy was to enable older people to live in their own homes for as long as possible. In consequence, the principal objective of the report was the development of a community care service. In addition, reform of residential or institutional care (as it was then referred to) for older people was proposed. *The Care of the Aged* (1968) acknowledged that the County Home was perceived as a place of last resort with the result that residents felt stigmatised. The report proposed to replace the County Homes by providing two types of long-term residential care:

- Geriatric hospitals to cater exclusively for older people needing continuous nursing care. Geriatric hospitals were to be associated with general hospitals. The intention was that specialists in geriatric medicine would have overall responsibility for long-stay hospital units assisted by local general practitioners.
- Welfare homes to provide for those older people "who do not need care in a hospital setting but for whom institutional care is required". These homes were aimed at people who were less dependent and described as merely frail, or who were admitted to institutional care for mainly social reasons.

The report also acknowledged the role of voluntary providers of long-term residential care. Under the 1953 Health Act voluntary, usually religious, organisations who provided long-term residential care received a capitation[1] grant. *The Care of the Aged* (1968) recommended a continuing and extended role for this sector based on a contractual arrangement between voluntary organisations and the health authorities, subject to an inspection procedure being implemented. The report also recommended that research be carried out into the need for long-term residential care.

Private provision of long-term residential care facilities was not discussed in *The Care of the Aged* (1968). The Homes for Incapacitated Persons (1964) legislation had acknowledged the role of both the private and

1 Capitation means a payment made for each bed occupied.

voluntary sector in providing long-term residential care. This legislation provided for standards, inspections and the notification of all new establishments. However, these provisions were confined to the private sector and did not require registration of homes. Additional regulations on standards published in 1966 were criticised as being too liberal.

The 1970 Health Act, which established the health boards, introduced the concept of ministerial approval of institutions outside the statutory sector providing in-patient services. The Act also provided for the payment of subventions by health boards for beds in all approved private nursing homes. Subvention payments were to be made, in accordance with ministerial regulations based on beds occupied rather than based on the means or dependency of the resident. Throughout the 1970s many voluntary and private institutions sought and were granted ministerial approval and payment. In 1980, the Department of Health ceased approving homes for budgetary reasons. However, other funding arrangements were made available, particularly for the voluntary sector, in the form of an annual budget, with welfare homes being granted lower levels of capitation.

O'Shea *et al* (1991) observed that for the duration of the period covered by *The Care of the Aged* Report from 1968 to 1988, changes occurred in the composition of long-term residential care for older people. The number of new welfare homes had been growing during the 1970s but this growth was arrested in the 1980s. There was also a decline in the number of public long-stay beds and a reduction in the number of older patients in acute hospitals and psychiatric institutions. However, during the same period, there was a dramatic increase in private sector long-term residential care provision.

2.3 *The Years Ahead* and Long-Term Residential Care

In 1988, a Working Party on Services for the Elderly produced The Years Ahead: A Policy for the Elderly, which replaced *The Care of the Aged* (1968). Between 1968 and 1988 community services had remained underdeveloped despite the recommendations in *The Care of the Aged* (1968). In consequence, *The Years Ahead* (1988) reiterated the need to move the emphasis from institutional care towards care in the home and the community.

The key recommendation of *The Years Ahead* (1988) relating to statutory long-term residential care was that long-stay hospitals should be radically restructured to enable them to function as community hospitals. They would continue to provide long-term residential care but would be more active in providing assessment and rehabilitation for patients than long-term residential facilities had previously. The intention was that such facilities would provide a mix of services including long-stay care, convalescent care and respite care, information, advice and support for carers in the community. A central element of the approach taken by *The Years Ahead* (1988) was the need for pre-admission assessment and post-admission rehabilitation under the guidance, wherever possible, of a specialist physician in geriatric medicine.

In *The Years Ahead* (1988) the private nursing home sector was explicitly recognised for the first time in a policy document. This was prompted by the substantial growth in the sector and the high subsidies being paid by health boards to nursing homes by this time under the terms of the 1970 Act. The report recommended the introduction of a licensing system for long-term residential care facilities in the private and voluntary sectors. A further recommendation was that subsidies should be determined on the means and dependency of residents rather than the beds provided in homes. According to the report, subvention approval should be granted on the basis of assessed need for long-stay care by a specialist geriatrician or close substitute.

2.3.1 The Health (Nursing Homes) Act 1990

Many of the recommendations relating to long-term residential care set out in *The Years Ahead* (1988) were incorporated into the Health (Nursing Homes) Act, 1990. Before the 1990 Act no effort had been made to plan for the integration of private nursing homes with public sector provision. The effects of the 1990 Act were to improve regulatory control, rationalise subventions paid to the sector and integrate private nursing homes into the general system of care for older people. The Health (Nursing Homes) Act included:

- repeal of the section of the 1970 Health Act that provided for the funding of beds in institutions outside the statutory sector,
- the introduction of a tiered system of subvention for people entering long-term residential care varying in accordance with means and dependency levels,
- the extension of regulation and inspection to the voluntary home sector. This meant that both the private and voluntary sectors became subject to regulation.
- greater quality control measures through:
  - i) compulsory registration;
  - ii) stricter enforcement of standards of design, nursing care, nutrition, general management;
  - iii) greater accountability of proprietors and stiffer penalties for offenders;
  - iv) better information and complaints procedures for the consumer.

This Act remains the basis for the regulation of private and voluntary long-term residential care in Ireland.

2.3.1.1 Subvention Provisions Under the 1990 Act

To qualify for a subvention under the provisions of the 1990 Act a person must be
(i) sufficiently dependent to require maintenance in a nursing home and
(ii) unable to pay any or part of the cost of maintenance in the home.

Dependency criteria

Three levels of dependency were provided for as follows:

1. medium, where one requires supervision,
2. high, where one has a combination of physical and mental disabilities and requires assistance,
3. maximum, where one has very restricted mobility and requires assistance with all aspects of physical care thus needing constant nursing care.

The Act provides for assessments to be carried out by a doctor, nurse, occupational therapist or physiotherapist on behalf of the health board. At present the system of subvention for nursing home care is being reviewed under a joint initiative by the Department of Health and Children and the Department of Finance.

Means criteria

For the purposes of a subvention, means are based on the income of the applicant and the value of his or her assets plus the income and value of assets of his or her spouse.

An applicant satisfying the dependency and means conditions is entitled to a subvention.

2.3.1.2 Regulation and Quality Control Under the 1990 Act

Regulations were introduced in 1993 to give effect to the quality control measures contained in the 1990 Act. The 1990 Act has been criticised for its provisions regarding quality control and standards of care. The first criticism is that the statutory sector is exempt from quality controls and inspections which apply to the

voluntary and private sectors. The second criticism is that the standards are difficult to enforce because they are open to interpretation by inspection teams.

Detailed regulations for these standards were drawn up under the following headings:

- welfare and well-being;
- contract of care;
- personal possessions;
- discharge from a nursing home;
- staffing;
- accommodation and facilities;
- design;
- kitchen facilities;
- hygiene;
- sanitary facilities;
- nutrition;
- information about the nursing home;
- register and records;
- death of a dependent person;
- inspections by designated officers;
- complaints;
- fire regulations;
- medical preparations and treatment;
- provision of services by health boards;
- training;
- registration certificate;
- insurance and enforcement.

However, measurable standards were established for only a small proportion of these elements of care. In many cases, the terminology used, such as 'adequate', 'sufficient', 'reasonable' and 'appropriate', is open to different interpretations. This results in inconsistencies in the application of standards between health boards and even between inspection teams within health boards.

In 1995, a voluntary Code of Practice for Nursing Homes was prepared and agreed by a group of people representing proprietors of nursing homes, health boards, carers and others with experience in the care of older people, and was published by the Department of Health. The Code aimed to generate a better understanding of what is involved in providing quality care to nursing home residents. However, the evidence from this study suggests that the Code has received little attention.

2.4 Findings of *A Review of the Recommendations of The Years Ahead*

A review of the recommendations of *The Years Ahead* (1988) was undertaken by the Council in 1997. *The Years Ahead Report: A Review of the Implementation of its Recommendations* (Ruddle *et al.* 1997) included a review of the recommendations relating to long-term residential care provision. Overall, the review concluded that development of community hospitals had not occurred in the manner envisaged by *The Years Ahead* (1988) between 1988 and 1997. Any development of community hospitals that had occurred had been slow and *ad hoc* because financial allocations to this sector were far below the level recommended by the Working Party. In consequence, community hospitals were unevenly distributed throughout the country.

The review also found that not all community hospitals provided assessment and rehabilitation. Further findings showed that there were different arrangements for assessments across the health boards. The review found that the level, extent and adequacy of support facilities and professional expertise available to community hospitals differed across health boards and across community care areas within health boards, again due to inadequate funding. In addition, the number of long-term residential care beds provided by health boards at the time of the review were above the norm recommended in *The Years Ahead* (1988). This was due to two factors:

(i) the failure to invest in the development of community care services resulted in higher demands on residential care,

(ii) the norms were considered to be inadequate in the light of demographic changes and projections.

Furthermore, the development of welfare accommodation has been mostly *ad hoc* with very few welfare home places provided by health boards. From 1988, the number of beds in welfare homes has been falling and the provision of places for this type of accommodation has fallen below the norm envisaged by *The Years Ahead* (1988).

Concurrently, private nursing home bed provision has increased significantly particularly in the Eastern Health Board area. The review envisaged that this trend would continue as a result of a number of factors including:

- the ageing of the population,
- changes in the social structure, particularly women's increased participation in the labour force and an associated decrease in their participation in informal care provision,
- the falling number of long-term residential care beds in the public sector.

2.5 Recent Developments

In the 1998 and 1999 budgets, the Minister for Finance introduced tax incentives to encourage the construction of nursing and convalescent homes by the private sector. These measures effectively extend capital allowances already available for industrial buildings and hotels to nursing homes and convalescent homes, with the result that the full cost of construction of a qualifying nursing home is allowable against tax over a seven-year period. These measures indicate a policy of promoting provision of long-term residential care by the private sector as a means of meeting the current trends in demand for long-term residential care.

Overall, the legislation providing for private nursing homes and subventions, and the other measures mentioned above, has led to the allocation of resources to this component of services for older people which has not been matched by a similar level of investment in non-residential care services. Ruddle *et al* (1997) noted that during the period 1993-1997 over £65m had been spent on the implementation of the 1990 Act compared with £2.5m spent on the development of day-care facilities. This calculation was made before the announcement of capital allowances.

2.6 Conclusion

This overview describes how long-term residential care has been provided in Ireland and the nature of the regulation and quality control measures which have been introduced. It is important to note the variety of facilities providing long-term residential care as well as the level of provision by each of the three providers. Long-term residential care facilities in Ireland comprise health board geriatric homes/hospitals; health board welfare homes; health board district/community hospitals; voluntary geriatric homes/hospitals; private nursing homes and psychiatric hospitals/units. Table 1 shows the number of older people in long-term residential care in 1996[2]. The statutory sector accommodated 8,272 older people in long-term residential care, the voluntary

2. The last year for which data is available from the Department of Health and Children.

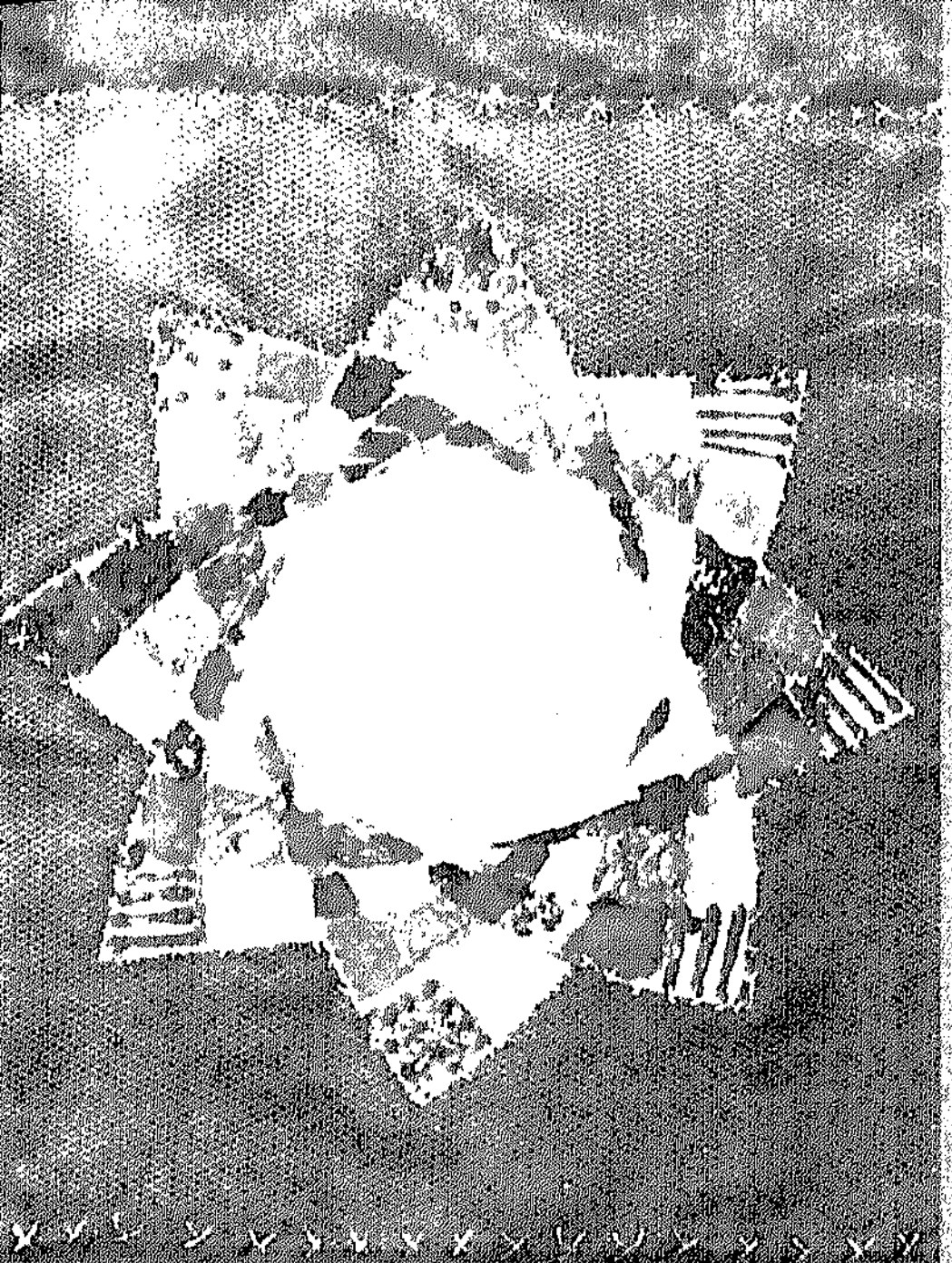
sector accommodated 3,221 people and the private sector accommodated 5,595 people. All the indicators show that the private sector is expanding while the public sector has been contracting. It is in this context that the quality standards must be developed and implemented in long-term residential care.

Table 1: Numbers of Older People in extended care facilities in 1996* by age group:

Age	Health Board Geriatric Homes/ Hospitals	Health Board Welfare Homes	Health Board District/ Community Hospitals	Voluntary Geriatric Homes/ Hospitals	Private Nursing Homes	Total
65 -69	386	67	141	132	162	888
70-74	733	112	262	286	406	1799
75-79	1063	160	425	488	917	3053
80-84	1359	263	575	816	1718	4731
85 years and over	1678	354	694	1499	2392	6617
Total	5219	956	2097	3221	5595	17088

Source: Health Statistics, Department of Health 1996

*This excludes acute care and psychiatric care long-term beds.



Chapter 3:

A Study of the Current Situation Regarding Quality in Long-term Residential Care

Chapter 3

A Study of the Current Situation Regarding Quality in Long-Term Residential Care[3]

3.1 The Study

A study to assess the current situation regarding quality in long-term residential care from the perspective of providers, medical professionals and health administrators was commissioned by the Council. The study consisted of:

- a survey of providers of long-term residential care in the public, private and voluntary sectors,
- consultations with medical professionals and health board administrators.

3.2 Survey of Providers

Long-term care facilities in Ireland comprise health board geriatric homes/hospitals; health board welfare homes; health board district/community hospitals; voluntary geriatric homes/hospitals; private nursing homes and psychiatric hospital/units. A postal survey was used to administer questionnaires to managers of the total population of 580 long-term care facilities identified.

The questionnaire asked providers to indicate:

- details of any quality initiatives in operation in their facility.
- the factors that they felt contributed to quality care.
- their aspirations for the future of the service.
- their views on the benefits of introducing a national quality monitoring policy.

Thirty per cent, or 170 facilities, were represented in the final survey responses.

3.2.1 Quality Initiatives

Just over half of respondents (53%) had quality initiatives . The quality initiatives cited can be grouped into the following categories:

- Therapies
- Individual Assessment
- Care Practices
- Policies
- Staffing
- Recreational Activities
- Buildings / Facilities

Therapies were the most frequently mentioned quality initiatives across all facilities. Voluntary and private facilities were more likely to report initiatives associated with recreational activities. Health board facilities were more likely to be engaged in initiatives aimed at improving the standards of buildings. Many health boards long-term residential care facilities are housed in older buildings, some of which were previously County Homes. A programme of up-grading and re-furbishing these buildings as well as replacing and providing additional facilities is underway.

3. The findings reported on here are based on research carried out on the Council's behalf by Ms Gail Birkbeck and Ms Christine Linehan from the National Research Agency.

In contrast, private and voluntary homes are subject to the Health (Nursing Homes) Act 1990, which requires them to meet specified minimum standards in buildings and facilities.

A number of respondents who did not have quality initiatives in place, believed that such initiatives depended on the support and assistance of the health boards.

3.2.2 Factors Contributing to Overall Quality of Care

In the survey, staffing was identified as the most important factor contributing to overall quality of care. A number of respondents highlighted the problem of attracting and retaining skilled staff, with many emphasising the need to develop training policies and appropriate measures to retain staff. Buildings, facilities and care practices were also identified as important factors contributing to quality of care.

3.2.3 Aspirations for Future Service Provision

Many care providers believed that the standard of services in the future depends on policies and reform at health board level. Almost one-third of all respondents believed that future care for older people should be predominantly community based.

3.2.4 National Quality Monitoring Policy

Over two-thirds of respondents were of the opinion that the introduction of a National Quality Monitoring Policy would be beneficial. Differences of opinion among care providers in private nursing homes and those working in health board units were evident with higher proportions of respondents from the statutory sector in favour of a national policy. Many providers from the private and voluntary sector who are currently subject to an inspection system to determine adherence to standards set out in the 1990 Act felt that this system was sufficient.

There was a strong consensus that any such policy should apply to all long-term care facilities: state, voluntary and private.

A large proportion of respondents raised the issue of resources. They agreed that adequate resources should be made available to enable long-term residential care facilities to have the staff and finances required to implement quality standards.

3.2.5 An Overview of the Survey Findings

The survey findings indicate that many care providers would welcome a policy on quality in long-term residential care. The factors that the respondents identified as contributing to overall quality of care, together with respondents' aspirations for future long-term care services, might form the basis of a new quality monitoring policy.

These factors were as follows:

- staffing issues,
- standards of buildings and facilities,
- care practices,
- individual assessment mechanisms,
- the use of therapies and recreational activities,
- policies guiding care provision,
- development of community services.

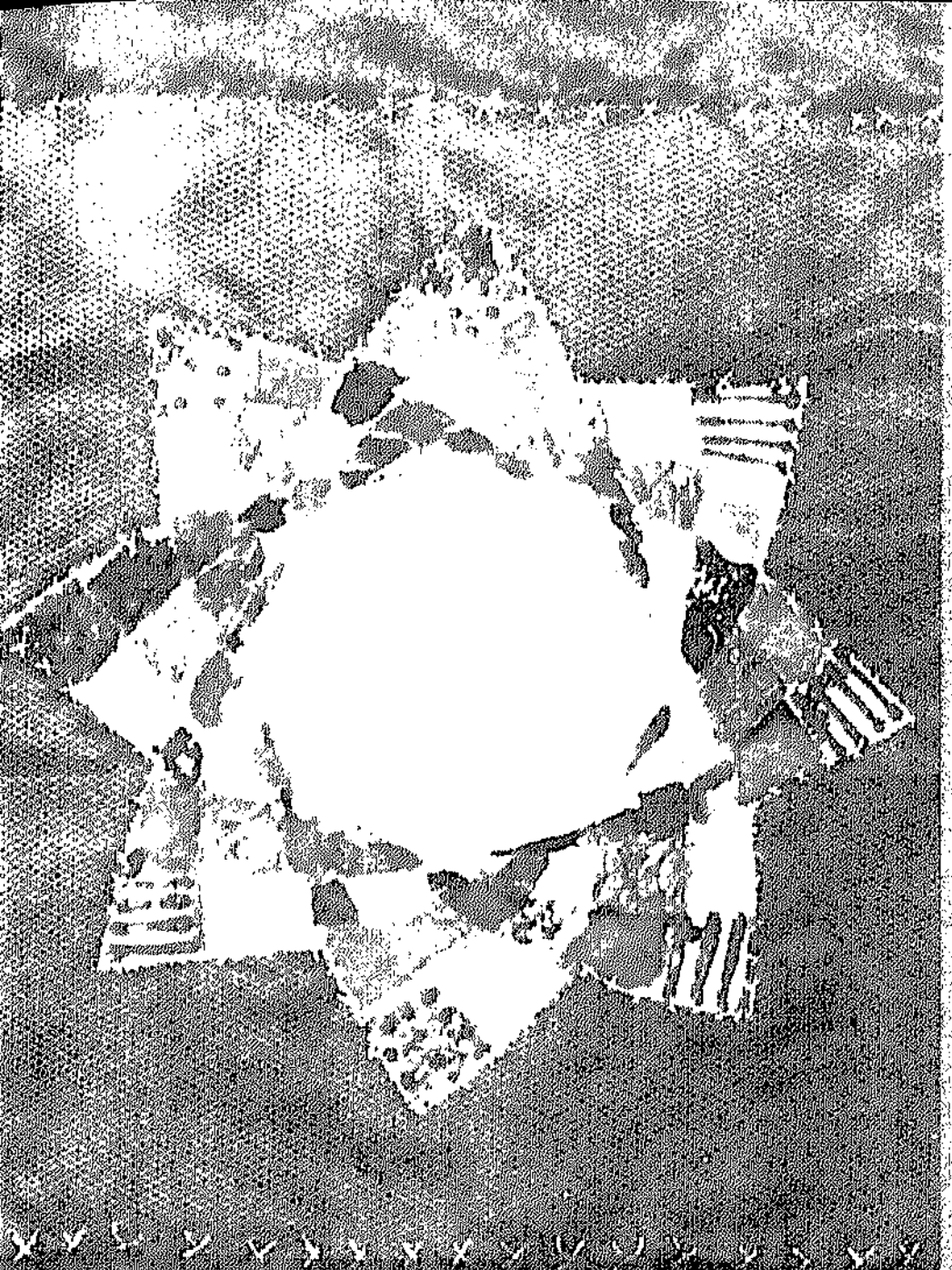
3.3 Consultations with Medical Professionals and Health Board Personnel

The study also included consultations with medical professionals and health board administrators involved in the provision of services to older people. Interviews were held with co-ordinators of services for the elderly, area co-ordinators, regional co-ordinators of services for older people, managers of special hospitals, programme managers of services for older people and a quality co-ordinator. The aim of the consultation was to identify their views on quality in long-term residential care and to consider the Council's proposal to develop national quality standards.

The majority of medical professionals and health board personnel responded that quality initiatives were already in operation in continuing care facilities they were involved with. Many of the initiatives identified were similar to those identified in the postal survey of care providers, e.g. therapies. Among the factors recognised as contributing to overall quality of care were resources and directives or protocols. Again, financial resources and legislation were identified as central to ensuring overall quality of care.

Almost all respondents believed that a national quality monitoring policy should be implemented in long-term residential care services for older people. Many commented that nursing home legislation is minimal and drew attention to the current absence of legislation governing the provision of services for older people. They advocated the introduction of uniform standards across all long-term care facilities: state, voluntary and private. However, all the respondents recognised that the introduction of such a policy would be a challenge and would require a significant investment of resources.

With regard to aspirations for future service provision, all the respondents included in the consultations agreed that quality standards should be implemented through the development of detailed guidelines.



Chapter 4

A Framework for Quality in Long-term Residential Care Proposed by the National Council on Ageing and Older People

Chapter 4

A Framework for Quality in Long-Term Residential Care Proposed by the National Council on Ageing and Older People

The quality of [residents'] lives is dependent upon the nature and quality of the care provided by those who work in institutions catering for the elderly.
(The Years Ahead: A Policy for the Elderly, 1988: 147)

The elderly population is increasing, and will grow rapidly after 2006. The increase in those reaching advanced old age is particularly significant. The implications of this growth for services must be faced ..... On the assumption that society wishes to do the best it can for its elderly citizens, resources will have to be diverted to support the elderly.

We recommend that the Government should, in the light of the changing demographic trends, adopt a conscious long-term policy of redeploying resources to services for the elderly.
(The Years Ahead: A Policy for the Elderly, 1988: 173-5)

4.1 Financing Long-Term Care

We have long known that our population is ageing, that the pace of the ageing of the population is due to accelerate, and that commensurate increases in services for older people are required.

Following publication of *An Action Plan for Dementia* (1999) and in light of the findings of the survey of providers' views of quality in long-term care in Ireland, **the National Council on Ageing and Older People believes that it is now imperative that significant real term increases in financial resources are made available to services for older people each year for the next five years.**

This is to ensure both that older people have access to community and residential services at levels appropriate to their needs and that these services are of a sufficiently high standard to deliver the benefits they were set up to achieve. Only in this way will the stated objectives of public policy in regard to health and welfare services for older people be realised.

These objectives are:

i. to maintain elderly people in dignity and independence in their own home;
ii. to restore those elderly people who become ill or dependent to independence at home;
iii. to encourage and support the care of the elderly in their own community by family, neighbours and voluntary bodies in every way possible;
iv. to provide a high quality of hospital and residential care for elderly people when they can no longer be maintained in dignity and independence at home.
(*The Years Ahead,* 1988)

The cost of long-term residential care should be equitable and not cause added distress to people who need to avail of it. The Council believes that the review of subventions currently being undertaken should take account of

the continuing and respite care needs of ill or disabled older people living in long-term residential care or in the community and their ability to pay for such care.

The Council is pleased to learn that the Department of Social, Community and Family Affairs is about to embark on a study of financing arrangements for long-term care. The Council understands that this study will consider a range of alternative financing arrangements including the current system, a social insurance system or a system involving a combination of public and private financing schemes. The Council is hopeful that the study considers the issues of quality and equity in accessing long-term residential care.

4.2 The Objectives of Care: Health and Social Gain

The Council is mindful that "choices in the use of resources are made every day at all levels of the services" and "that there are not, and could never be, sufficient resources to meet all the needs which can be identified", as stated in *Shaping a Healthier Future: A Strategy for Effective Healthcare in the 1990's* (1994: 16).

The national health strategy as outlined in *Shaping a Healthier Future* (1994) indicates that choices must be made on the basis of outcomes measured by reference to health gain and social gain anticipated from services.

> *Health gain is concerned with health status, both in terms of increases in life expectancy and in terms of improvements in the quality of life through cure or alleviation of an illness or disability or through any other general improvement in the health of the individual or the population at whom the service is directed.*
>
> *Social gain is concerned with broader aspects of quality of life. It includes, for example, the quality added to the lives of dependent elderly people and their carers as a result of the provision of support services. (Shaping a Healthier Future, 1994:16)*

The Council believes that long-term residential care is a critical part of the continuum of care services; it should be provided to such a standard to those older people who can no longer be maintained in dignity and independence at home that they experience both health gain and social gain from the service. Attention must focus unequivocally on the quality and effectiveness of long-term care services, rather than on the provision of such services to a minimum standard.

4.3 The Role of the Department of Health and Children

The Council believes that this change in focus requires the support of the Department of Health and Children in the following ways:

4.3.1 Statement of Policy

An authoritative statement of policy on prevention, assessment, rehabilitation, standards of care, and the maintenance of independence and dignity in continuing care is required.

4.3.2 Ensuring Uniformity of Standards

The Council acknowledges that much progress has been made through the implementation of the Health (Nursing Homes) Act, 1990 and the introduction of the Code of Practice for Nursing Homes in 1995. However, as stated in the Council's report, *The Role and Future Development of Nursing Homes in Ireland* (1991), the different arrangements applying to private and voluntary homes on the one hand, and to the long stay

institutions run by health boards on the other, makes it more difficult to ensure that the quality of long-term residential care is of a uniformly high standard across all sectors. **Nonetheless, the Council believes that standards should be raised uniformly throughout the long-term residential care sector, including in public facilities.**

4.3.3 Establish an Independent Inspectorate

To ensure uniformity of standards, the Council recommends that the Department reconsider the recommendation of the Working Party on Services for the Elderly for the establishment of an independent inspectorate of extended care facilities for the elderly within the Department of Health comprised of people with first-hand experience of providing high standards of care for the elderly (*The Years Ahead,* 1988: 147). This inspectorate might be established within the Department's new Social Services Inspectorate.

4.3.4 Develop Quality Assurance Mechanisms

The Council also recommends that the Department require all long-term residential care institutions to produce a quality assurance policy statement and a quality assurance service plan, and that it take other such measures as will facilitate and encourage these institutions to improve the quality of both the nursing and the social care services they provide. To this end, the Council recommends that the Department of Health and Children:

(a) publish national quality standards and guidelines for long-term care in Ireland to assist those required to produce quality assurance policy statements and quality assurance service plans for private, voluntary and state facilities. Standards should specify clearly performance targets and indicators;

(b) introduce mechanisms to promote, encourage and foster quality assurance equally in all private, voluntary and health board long-stay facilities.

4.3.5 Establish a Working Group

The Council further recommends that the Minister for Health and Children or the Minister of State with responsibility for older people establish a representative Working Group on Quality Assurance in long-term residential care with the following terms of reference:

i. to review measures taken in other jurisdictions to promote quality standards in long-term residential care facilities,

ii. to develop and pilot national quality standards and guidelines, and to advise on the implementation of such standards and guidelines,

iii. to advise on mechanisms to promote, encourage and foster quality assurance in all long-term residential care facilities, taking into consideration the experience of other countries and the experience of health board officials responsible for the inspection of nursing homes in Ireland.

4.4 Develop the Continuum of Care

The Council is aware that the quality of service provided in long-term residential care cannot be maximised in isolation from other services, including special housing provision and various community care services, which together make up the continuum of care for ill, disabled and older people with varying degrees of dependency.

To conclude, the Council reiterates the view expressed in *The Role and Future Development of Nursing Homes in Ireland* (1991) which stated that such upgrading of standards across the whole long stay sector should occur in conjunction with the direct provision by the health boards of additional facilities, community hospitals, psychogeriatric facilities and other special centres where appropriate (O'Shea *et al.* 1991: 14). The Council believes that care standards in all long-term care facilities across all sectors should become subject to nationally agreed standards and quality assurance arrangements whose implementation needs to be overseen by an inspectorate established within the Department of Health and Children.

4.5 Further Research

The Council believes that research on effectiveness in long-term care is needed. Such research must include the following:

- an assessment of the effectiveness of long-term residential care in terms of the availability and admission waiting times for those who have an assessed need for such care;
- a review of existing assessment procedures used to determine need for long-term residential care and other alternative community provision in all health board regions.

Chapter 5

Report on the Council Seminar: *Fostering Quality in Long-Term Institutional Care for Older People in Ireland.*[4] 29 May 2000

The National Council on Ageing and Older People hosted a seminar entitled *Fostering Quality in Long-Term Institutional Care for Older People in Ireland,* on 29 May 2000. The purpose of the seminar was to discuss the issue of quality in long-term residential care from a diversity of perspectives and discuss the Council's proposed framework for fostering quality in this area. A summary of the key discussion points is presented here.

5.1 Financial Resources

It was accepted among delegates that there would be additional costs for the long-term residential care sector in implementing measures to ensure high quality care for vulnerable and dependent older people. Therefore, it was recognised that there is a need for increased funding for long-term residential care.

Delegates examined how resources for services for older people are currently allocated and identified the following concerns:

- Within the long-term residential care sector, the increasing number of subventions payments has meant proportionately more resources are allocated to private sector provision. The decision of the Minister for Finance in 1997 to extend capital allowances to nursing homes indicates an intention to continue this trend. Delegates associated this development with a move away from the direct provision of care by health boards.

- Resources for services for older people have been disproportionately allocated to long-term residential care services. This situation is contrary to the central policy tenet of supporting older people to live at home for as long as possible. It was proposed that resources could be better spent if they are directed at the individual older person who needs care and not at the service. One health board gave an innovative example where the subvention payment has been made to carers to finance the care of an eligible older person at home. The use of subvention payments to fund care in the community was identified as a viable alternative to residential care and a creative use of resources.

5.2 Community Care Services

Home supports such as Home Help and Care Assistants have the potential to support dependent older people to continue to live at home. The delegates agreed that investment in these services is justified on the grounds that this is in keeping with the current policy objective of enabling older people to live at home for as long as possible.

5.3 Standards of Care

Delegates recognised that although the 1995 Code of Practice is useful, it is not mandatory. Consequently, there had been a low level of observance of the Code. Delegates thought that specific guidelines and legislation on standards of care would contribute to older people in long-term residential care experiencing health gain and social gain.

4. See full programme in Appendix 1.

Delegates identified shortcomings in the system of inspection required by the Nursing Homes Act, 1990. The Guide to the Nursing Homes Legislation and Guidelines for Inspection of Nursing Homes intended to set out the standards required by the act is still in draft form. The terminology used in current legislation such as 'suitable' and 'sufficient' is open to interpretation by inspectors. Consequently, there have been inconsistencies in the implementation of standards between health boards, community care areas and even individual inspection teams. These inconsistencies undermine the concept of service level standards.

Additionally, capital allowances which act as incentives for the private sector to provide nursing homes should have been accompanied by a regulatory framework for standards on facilities' size and design.

When devising standards of care, delegates proposed that a quality policy should address specific issues such as caring for older people with dementia and other related cognitive impairments.

Finally, delegates agreed that medical and care staff, older people resident in long-term care, their relatives or carers and older people's advocacy groups need to be involved in the process of developing standards.

5.4 Process of Moving into Long-Term Care

Two health boards presented the findings from studies they had conducted with older people in long-term residential care. The research illustrated that older people often feel they have little choice about moving into long-term residential care. In many cases older people had poor perceptions of residential care before entering the service and tended to have low expectations of it. The research showed that the process of entering residential care is often tainted by negative perceptions. Although the older people who participated in the research were mostly positive about the facilities and the staff, they often described their independence as reduced and redefined on entering care. Therefore, the process of moving into long-term residential care needs to be carefully planned in consultation with the prospective resident and his/her carers, where appropriate.

Additionally, delegates agreed that there is an onus on individual health boards and the Department of Health and Children to challenge these perceptions. The introduction of quality standards could assist in this task by providing prospective residents with clear detailed information on long-term care facilities and practices.

5.5 Assessment

Delegates felt that in order to guarantee a high standard of care it is necessary to identify the needs of older people entering long-term care through an assessment procedure. The assessment procedure ensures that older people with specific needs such as people with dementia are referred to units expressly designed to meet these needs. Therefore, it is important that a multidisciplinary team should be involved in the thorough evaluation of the health status of all older people entering residential care. The assessment should pay particular attention to any treatments or programmes of rehabilitation that could improve the person's health status through the alleviation or cure of an illness or condition.

5.6 Maintenance of Independence and Dignity

While the main objective of services for older people is to safeguard the older person's dignity and independence, delegates questioned whether this had been achieved. Limited access to therapies and medical aids for older people both in the health board and voluntary/private nursing homes, even for GMS[5] card holders, has the potential to undermine residents' rights. In particular limits on the supply of incontinence

5. General medical services card holders are entitled to free use of public health care services.

pads were criticised as being dehumanising and detrimental to the comfort, dignity and well-being of the older person.

A greater respect for older peoples' autonomy should be a central aim of policies designed to raise care standards. Residents should be guaranteed the right to retain some independent income as one means of promoting autonomy. At present older people in private nursing homes often sign over their pension in full as a contribution towards their care. Delegates felt that if older people retained an amount each week their independence would be greatly enhanced. This is the case in public facilities and highlights the need for uniformity across facilities.

Delegates thought that policies to promote quality in long-term residential care should focus on daily routines. The daily routines need to be organised to provide residents with choices. Choice promotes independence and gives patients the opportunity to exercise control over their lives. Furthermore, it helps to keep one's mind active and avoid deterioration in mental health.

5.7 Uniformity of Standards

The Council recommended that standards should be raised uniformly throughout the long-term residential care sector, including the health board long stay facilities. Uniform standards should apply equally to all care providers including health board facilities. At present only private and voluntary facilities are subject to health board inspections as set out in the Health (Nursing Homes) Act, 1990.

An Independent inspectorate and a Working Group on Quality Assurance are the mechanisms proposed by the Council to implement this recommendation. This proposal was strongly endorsed at the seminar.

5.8 An Independent Inspectorate

Currently, health board inspectors carry out inspections and investigate complaints of private and voluntary long-term care facilities. Under the framework proposed by the Council, health board facilities would also become subject to inspections. It would be inappropriate for the health boards to continue to have the responsibility for conducting inspections.

The Council's proposal to establish an independent inspectorate was endorsed at the conference by the delegates. The inspectorate should be comprised of people with first hand experience of the long-term residential care service. A separate unit is also needed to investigate any complaints made about a care facility or individual staff member.

5.9 Partnership between Public and Private Facilities

Representatives of the private sector stated that the sector is currently on the periphery of policy-making. Representatives believed that the private sector could play a more active role in decision-making and policy development. Some health boards have already developed partnerships with nursing home proprietors and these were welcomed as beneficial initiatives. Examples of some of the health boards' initiatives were as follows:

- seminars on topics relevant to caring for older people in a residential setting, such as nutrition and older people,
- infection control in nursing homes,
- accident prevention in response to requests from private providers.

It was recognised that any initiative to develop quality standards will only be effective if it involves the participation of both public and private providers. Such initiatives should incorporate all providers' perspectives on long-term care to promote consistency in the interpretation and implementation of agreed standards.

The partnership should strive to make the transition of an older person from public health services to private sector services easier. At present, when an older person is about to be discharged from a hospital to come under the care of a private nursing home, there is no liaison between the two facilities. Policies should provide for improved liaison between the different services through the formulation of discharge procedures and the provision of a mechanism for partnership.

Delegates concluded that the achievement of quality is dependent on the establishment of partnerships among all sectors involved in the provision of long-term care for older people.

5.10 Consulting Older People in Long-Term Care

The usefulness of adopting a consumer-orientated approach to evaluating long-term residential care was questioned by some delegates because the current organisation of long-term residential care means that residents are often not in a position to make any choices. In this context, residents could sometimes be passive participants in the decision-making process. However, delegates believed that the emergence of a consumer culture generally and its diffusion into the health services will lead to greater demands and higher expectations among residents of long-term care in the future.

In addition, the low expectations expressed by participants in the health board's research mentioned above, should be taken into account when designing methods of evaluating care.

5.11 Quality Assurance Policy Statement

The Council recommended that the Department of Health should require all long-term care institutions to produce a quality assurance policy statement and a quality assurance service plan. Seminar participants endorsed this proposal. Individual facilities should be encouraged to evaluate services in light of their quality assurance policy statement and should develop service plans with reference to the policy statement. The current system of health board inspections is largely perceived as a monitoring procedure and as an inspection to be passed rather than as a means of fostering quality services among cares providers. The Department of Health and Children should undertake to identify and disseminate models of best practice in residential care to the public and service-users.

An effective quality policy should begin with an education programme for staff and residents focusing on the benefits that adoption of a quality policy would have for residents, staff and the care facility.

5.12 Dimensions of Quality Residential Care

Seminar participants identified a number of factors that contributed to the quality of care. These were as follows:

- **Medical Care.** Many older people in residential care have medical conditions requiring very complex care. There is a need to ensure that all older people in residential care have access to medical and paramedical services, day care and all other nursing services available according to their needs.

- **Physical Environment.** It is recognised that though the home environment can never be fully replicated, the physical environment may give residents a sense of physical and psychological security. Therefore, attempts should be made to make facilities more homely and facilitate independent living. The term 'home' needs to be kept in focus when developing high quality care environments.

- **Occupational Environment.** It is important that service-users have the opportunity to become involved in daily activities. Unfortunately the occupational environment of residential care settings is often limited. Many of the activities on offer to older people are solitary and passive such as reading, watching TV, or listening to music or the radio. A range of activities suitable for people with differing levels of dependency should be made available. In addition, staff levels need to be at a sufficient level to ensure that dependent patients can take part in such activities. Providing residents with the opportunity to contribute to the daily activities of the unit can greatly enhance the occupational environment. Due consideration should also be given to the important role that pastoral services and religion play in the lives of many older people in long-term care.

- **Social Environment.** The social environment of a hospital or care setting comprises the staff, visitors and other residents. Staff members are normally the first contact a patient has with the social environment. Although staff play a major role in the lives of the residents, the nature of the interaction means that staff often remain as strangers to residents. Research on residents in health board long-term care facilities found that there is a perception among older people that staff levels might sometimes be inadequate. Consequently, older people often do not ask for assistance because they do not wish to burden staff. This highlights the key role that human resources play in the provision of quality care.

5.13 Staffing Issues

Finally, a number of matters were raised by delegates in relation to staff and human resources in residential care.

5.13.1 Recruitment

Providers of long-term care described how it has become increasingly difficult to recruit staff into services for older people. This inability to recruit staff and the lack of opportunity for career progression shows the need for a restructuring of staff management. Conditions must ensure that nurses and care staff experience job satisfaction and a sense of empowerment. Nursing staff should not have responsibility for clerical, administrative, domestic and catering duties. Additionally, salary levels should be reviewed and the role that salaries play in attracting and retaining nursing and care staff be taken into account.

5.13.2 Staff Ratios

There is a need for specific legislation on staffing ratios. If quality care is to be achieved, then staff-patient ratios have to be maintained at an acceptable level.

5.13.3 Training

Nurses, care assistants and doctors who provide care for older people should have specific training in gerontology. Formal training for care workers is of particular concern. Training should be provided on an ongoing basis. Diplomas in caring for older people should be further developed and staff should be actively encouraged to undertake such training.

Chapter 6

Conclusion

This report by the National Council on Ageing and Older People sets out a framework for developing quality in long-term residential care for older people in Ireland. In the report, obstacles to a successful implementation of a quality policy have been identified. It is also acknowledged that certain conditions need to be met if a policy on quality in long-term residential care is to be fully realised. These conditions were as follows:

6.1 Commitment

The first is a commitment in principle from Government and in the provision of resources. Opening the Council's seminar on *Fostering Quality in Long-Term Institutional Care for Older People in Ireland*, the Minister of State at the Department of Health and Children, Ms Mary Hanafin, TD expressed a commitment on the part of the Government to ensure that older people have access to the best possible residential care available, whether it is in a general hospital, community nursing unit or nursing home. The Minister of State also identified the need to go beyond minimum standards, to protect the dignity of older people in long-term care and to ensure that the appropriate level of care is provided.

6.2 Resources

A second pre-requisite is adequate resources. An initiative that aims to implement quality in long-term residential care requires extra resources to finance the initial introduction of standards and to establish the necessary structures to maintain them.

In addition, plans need to be developed and implemented for financing long-term care. Changes in demographic trends, health policy objectives orientated towards health and social gain and the growth of a consumer culture all place demands on health services to plan for future provision. The Council is pleased that the Department of Social Community and Family Affairs is undertaking research on financing arrangements for long-term care. The Council believes that financing should be provided through a social insurance scheme that would guarantee social security in old age in the form of both pensions and long-term care.

6.3 Capital and Current Resources

Additional capital and current resources are both needed. The Council welcomes the Government's capital investment programme aimed at upgrading public long-term care buildings and providing additional facilities. Further capital investment is needed to provide more facilities to ensure adequate regional distribution. This investment will enable older people to access residential care within their own locality. The services, practices and facilities needed to ensure quality of care will also require additional day-to-day funding. A review of subventions is underway and the Council hopes that this will lead to recommendations for an improved level of subvention. Overall, the allocation of resources needs to be balanced. The Council is concerned that in the total budget for services for older people sufficient resources are provided for the development of community care services in addition to the resources required to ensure high quality residential care services.

6.4 Staffing and Human Resources

Staff and human resources are also fundamental to formulating and implementing quality standards in long-term care. The present skills shortage in the health sector is a particular problem. A career in caring for older people needs to be structured so that it is seen to be rewarding and fulfilling for staff. Consequently, the staff will be more committed to meeting the needs of older people in their care. Formal, accredited training that equips staff with skills to meet the care needs of older people and promotes their understanding of ageing will work to the benefit of those receiving care as well as improving staff morale. Working with a care programme which has the effect of improving the quality of life of older residents can in itself provide fulfilment for staff.

6.5 Conclusion

An adequate basic service structure in the form of resources, facilities and staff is the starting point for a quality care service. The development of resident-orientated environments, philosophies and practices which meet the health and social care needs of older people in long-term residential care requires much more. The Council's proposals are intended to provide a framework to develop a policy on quality standards and quality assurance standards and guidelines.

To conclude, the following factors should be addressed in the development of quality standards for long term residential care:

- the stated policy objectives of health and social gain for all health services,
- the objective of promoting quality of life having regard to the dignity, independence and autonomy of the older people resident in long-term care settings,
- the inclusion of all those involved in long-term care: older residents; advocates, relatives and friends of older people; care and medical staff; managers; administrators and planners,
- the need to implement standards uniformly across all sectors: public, private and voluntary,
- the need to specify clear performance targets and indicators in standards,
- the failure of the voluntary Code of Practice for Nursing Homes (1995) to make an impact on all long-term care facilities indicating the need for standards to be implemented on a legislative basis,
- the importance of an Inspectorate that is independent, comprised of people with first-hand experience of providing high standards of care for older people.

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Appendix 1

National Council on Ageing and Older People.
Seminar on Fostering Quality in Long-Term Institutional Care for Older People in Ireland, 29th May 2000.

the programme

Opening of seminar

9.00 **Introduction**
Dr Michael Loftus, Chairperson, National Council on Ageing and Older People

9.10 **Opening Address**
Dr Tom Moffatt TD, Minister of State at the Department of Health and Children with Responsibility for Older People

first session: presentation of findings from research

Chair: **Dr John Gibbon,** Consultant Geriatrician (retired) and Member, National Council on Ageing and Older People

9.30 Assessment of the Quality and Effectiveness of Long-Term Care Provision for Older People in Ireland
Ms Gail Birkbeck, National Research Agency Ltd.

10.00 Older People in Long-Term Care: A Qualitative Study
Dr David S Evans, Department of Public Health, Western Health Board

10.15 The Attitudes, Preferences and Perceptions of Older Persons to their Continuing Care Environments
Ms Heather Hegarty, Department of Public Health, Southern Health Board

second session: fostering quality under the health (nursing homes) act, 1990

10.30 **Discussion**

11.00 **Coffee**

Chair: **Mr John Sweeney,** Director, Irish Society for Quality in Health Care

11.30 A Health Board Perspective
Dr Sheila MacEvilly, East Coast Area Health Board

11.50 Experience of the Irish Nursing Homes Organisation
Mr Joe Stanley, Caiseal Gail Nursing Home, Galway

12.10 **Discussion**

12.45 **Lunch**

third session: keynote address

Chair: **Dr Margo Wrigley**, Northern Area Health Board and Member, National Council on Ageing and Older People

2.00 Developing National Standards for Long-Term Institutional Care for Older People in Britain
Dr Gillian Dalley, Director, Centre for Policy on Ageing, London

2.30 **Discussion**

final session: recommendations for future actions, panel discussion and open forum

Chair: **Mr Paul Barron,** Director, Blood Policy, Mental Health and Services for Older People, Department of Health and Children

3.00 Fostering Quality in Continuing Care for Older People in Ireland: Proposals from the National Council on Ageing and Older People,
Ms Catherine Conlon, Research Officer, NCAOP

3.20 Panel responses and discussion:

- **Dr Ken Mulpeter**, Consultant in Internal Medicines/Geriatrics, North Western Health Board
- **Mr Joe Stanley**, Irish Nursing Homes Organisation Ltd
- **Ms Celine Phelan**, Chairperson, Federation of Catholic Voluntary Nursing Homes
- **Ms Bridget Smith**, Co-ordinator of Services for the Elderly, North Western Health Board

4.00 **Open Forum**

4.25 **Closing Remarks**

4.30 **Coffee - End**

the seminar

Older people living in long-term institutional care may be regarded as being among the most vulnerable in our society by reason of the special supports and continuing care assistance they need. Therefore particular attention should always be paid to their requirements, and to fostering quality in the care they receive.

In proposing this seminar, the National Council on Ageing and Older People seeks to provide a platform for discussion of the issues relating to how quality in long-term institutional care is determined and how it may be improved.

Findings from research commissioned by the Council and from research undertaken by the Western and Southern Health Boards on aspects of quality in continuing care will be presented at the beginning of the seminar. Participants will have an opportunity to discuss the implications of these research findings. Much progress has been made in improving standards in private long-term care provision following the implementation of the Health (Nursing Homes) Act, 1990 and the introduction of the Code of Practice for Nursing Homes in 1995. The second session of the seminar will consider how quality is being fostered today under current legislation and the Code of Practice for Nursing Homes. Perspectives on fostering quality in private nursing homes will be presented at this session by a health board Co-ordinator of Services for the Elderly and a representative of the Irish Nursing Homes Organisation.

Dr Gillian Dalley, Director of the Centre for Policy on Ageing, London, was leader of the team responsible for the preparation of the Consultation Document on National Required Standards for Residential and Nursing Homes for Older People, commissioned by the Department of Health in Britain. Dr Dalley has kindly agreed to speak about the British experience of developing standards in long-term institutional care settings in a keynote address after lunch.

One of the most important distinctions in the literature on quality in care is between quality control on the one hand, which focuses on adherence to quality standards, and quality assurance on the other hand, which addresses quality of service to meet consumer demands. The Council has been conscious of the need to keep both perspectives in mind when developing its recommendations for future actions to promote quality in long-term institutional care.

The Council's proposals for fostering quality in all long-term institutional care settings for older people in Ireland will be presented at the last session. A panel of speakers will each briefly respond to these proposals and an open forum will conclude the day's proceedings.

It is anticipated that the seminar will be of interest to policy makers and planners concerned to ensure high quality standards in all long-term care settings where older people are supported and cared for. It will also be of interest to all those who provide public, private and voluntary long-term institutional care services to older people in Ireland. Often working under significant constraints and difficulties, they nonetheless remain concerned to provide the highest possible standards of service and care.

The Council will seek to record and produce the proceedings of the seminar to assist those responsible for developing and promoting quality in our health services and for all others with an interest in this endeavour.

Appendix 2

Developing National Minimum Required Standards For Care Homes for Older People in England and Wales

Dr Gillian Dalley, Director, Centre for Policy on Ageing

The issues raised in the Council's proposals on quality in long-term care have been on the agenda in England and Wales for some time. Standards have been developed and implemented in England and Wales to ensure a minimum quality standard of care for older people in long-term residential care.
The Council invited Dr Gillian Dalley, Director of the Centre for Policy on Ageing (CPA) to describe this process and the role played by the CPA. Dr Dalley delivered the following address at the Council's seminar on Fostering Quality in Long-Term Institutional Care for Older People in Ireland.

Introduction

Sixteen years ago, the UK government passed the Registered Homes Act 1984. At the same time the Centre for Policy on Ageing (CPA) published *Home Life* which the then Department of Health and Social Security had commissioned and subsequently endorsed as official guidance for the inspection of residential care homes.

Since its publication, *Home Life* has been regarded by inspectors and proprietors alike as 'the bible' and has been a major force in improving standards throughout the sector. During that time, however, the care home sector did not stand still. Indeed over the sixteen years, the whole context for the regulation and inspection of care homes was transformed. The independent sector (private and voluntary) grew and outstripped local authority provision; indeed, in recent years many local authority homes themselves have been transferred out of local authority control into the 'not for profit' independent sector or have closed. Under the NHS and Community Care Act 1990, the funding mechanisms changed with local authorities acquiring control over the assessment and access to care of over a third of all residents in care homes and the proportion is growing. During this time, independent providers complained that the regulatory arrangements were unfair to them. They claimed preferential treatment was given to local authority homes because they did not have to be inspected, inspection standards were often inconsistently applied by inspection units and individual inspectors, and there was widespread geographical variation in the standards that were required.

The Need to Develop Standards

CPA recognised the profound changes that had taken place and in 1996 published *A Better Home Life* which sought to unify the approach to standard setting across both residential and nursing home sectors and to recognise the changed circumstances brought about by the 1990 community care reforms. Government, too, recognised the disquiet felt within the sector and asked a former civil servant, Tom Burgner, to report and make recommendations on these changed circumstances.

This report was published at the end of 1996, and addressed many of the issues, calling for mandatory national standards and an end to the imbalance between the treatment of public and private provision. The new Labour Government elected in 1997 accepted the thrust of the report promising a White Paper which would look at the regulation of social services in general, including the regulation of residential care. As part of the preparation for this, the Department of Health commissioned the CPA, early in 1998, to draw up new national standards, which would eventually provide the basis for the inspection of older peoples' homes under a new regulatory framework.

A Legislative Approach

A White Paper - *Modernising Social Services* - was finally published after considerable delay in November 1998 and confirmed much of what the Burgner report had recommended. The Care Standards Bill based on the White Paper is now working its way through Parliament. In relation to residential and nursing home care, much will change under the system of regulation and inspection: the regulation of residential and nursing home care will be unified and be removed from the control of local and health authorities. A National Care Standards Commission is to be established to regulate homes throughout England with a separate commission for Wales; local authority homes will be registered and inspected on the same basis as independent sector homes and standards will be national and mandatory.

Developing Standards

The standards - national minimum required standards - developed by CPA during 1998/9 while the White Paper was being prepared, were completed and submitted to the Department of Health and Welsh Office early in 1999. They were the outcome of an extensive consultation process with all interested parties. A 35-strong Advisory Group chaired by Kina, Lady Avebury (who chaired the *Home Life* Working Party in 1984 and A Better *Home Life* Advisory group in 1996) and composed of representatives from the independent sector, inspection units, professional bodies, campaigning groups, academics and practitioners oversaw the work. Specialist groups were set up to look at particularly complex topics or contentious issues, including cultural matters, the needs of special groups (such as people with dementia or sensory impairment), staffing issues and the physical environment. A small group of inspectors was convened to comment on standards as they were developed. The CPA team met a wide range of individuals and groups who wished to express their (often strongly held) views and team members spoke at conferences and seminars during the year. Research staff at CPA conducted a trawl of inspection units' standards and other documentation to develop a broad picture of what constituted currently required and accepted standards.

The Standards

The standards which the CPA developed are basic standards applicable across the board to all homes for older people - both residential and nursing homes. They lay down a floor below which no home should fall. In that sense they are not aspirational.

The aim was not to set out best practice which only a minority of homes would ever be able to achieve but to lay down standards which are reasonable and which are considered by the vast majority of care home providers as accepted and acceptable practice. The aim was not to put care homes out of business but to ensure that all care homes provide a level of care which is of a standard acceptable to residents and their relatives and friends. They are standards which according to the Department of Health's brief to the CPA had to be:

1. **robust** enough to withstand differences of view amongst inspectors and care homes;
2. **measurable** so that there can be no dispute about what is being required of a home;
3. **enforceable** so that vulnerable older people can be assured that any home which is registered will meet the standards as laid down.

The emphasis throughout the document has been to observe the principles of care which underpin most good practices-privacy, dignity, respect, choice, fulfilment and safety. Because a national standard has to be measurable and not subject to the whim of different inspectors' interpretation, it has to relate to something tangible. So a standard cannot be about 'the feel of the place' or 'the ambience of the home'. Alongside each standard, however, evidence and expected outcome are stated and this can take account of some of these

qualitative aspects. Thus under a standard relating to privacy, the standard is that the staff should knock and wait before entering a resident's room. The evidence which an inspector should look for is through observation, discussion with residents, staff and managers, and inspection of training plans and records. The outcome is that staff understand the importance of observing the home's philosophy of care and are enabled to treat residents with respect and preserve their privacy.

Approach to Standard Setting

This threefold structure-standard, evidence and outcome-is crucial to the approach that CPA has adopted. The 'standard' is the measurable instrument while the 'evidence' and 'outcome' relate to the qualitative element which can be called upon to show that the intention behind the standard has been truly achieved. Critics of standard-setting sometimes argue that the very act of listing standards is mechanistic and antithetical to achieving the goal which they are designed to accomplish-namely, the assurance of a certain level of quality and achieved outcome. At worst, the routine ticking of a list of standards as 'having been met' may even mask poor practice. While acknowledging these problems, CPA also recognised that its chief task was not to establish a quality assurance system but to provide a tool for inspection and regulation. The threefold approach has thus been adopted in order to achieve a balance: the standards will provide a systematic and fair basis for judging 'fitness to trade' but because of the emphasis on evidence and outcomes they will also provide a firm base upon which quality improvement mechanisms can be constructed.

Aspects Covered by the Standards

The standards cover all aspects of living in a care home. Sections are devoted to:

- The home's brochure and prospectus;
- The rights of residents;
- Complaints procedures;
- Policies and protocols;
- Health and personal care;
- Daily life and social activities;
- Food and mealtimes;
- Dying and death;
- The physical environment;
- Management and administration;
- Staffing.

Accommodating Diversity of Facilities

The aim was to be comprehensive but not too detailed and prescriptive. The first section deals with the home's brochure and prospectus and provides the key to the general approach. CPA recognises that the care home sector is highly diverse. Homes, for example, may be large or small, run by private individuals or corporate organisations, meeting the needs of older people in general or those with special needs in particular, and be located in the town or the country. Each type of home will vary in its aims and objectives. It would be impossible therefore to draw up standards which could uniformly apply across this varied range. The standards dealing with the home's brochure and prospectus are designed to overcome the problem of drawing up standards which are applicable across the board but which can also take account of diversity. The standards require homes to set out in their brochure and prospectus what they are offering to prospective residents in terms of their philosophy of care, the size and lifestyle of the home, the special and cultural needs they are able to cater for and the specific services they have to offer. They can then be held to account against these published claims. Thus if a home says it caters for people with dementia, then the principles of

good dementia practice which it sets out in the brochure must be applied and observed. If a home says, for example, that it can cater for Muslim elders, it must be able to demonstrate that it can offer a halal diet, appropriate washing facilities and opportunities for religious observance.

Reaction to the Standards

The bulk of the standards are about the quality of life and quality of care in a home and aim to focus on the resident and her or his experience. Only one section deals with the physical environment. However, it is worrying that most comment from the independent sector has been along the lines 'the standards should be about quality of care and not the quality of the environment'. The comment is ill-founded and wrong. The standards are concerned with both and both are important. An older person moving into a care home ought reasonably to be able to expect a standard of accommodation which enables the resident to live comfortably.

The standard for room size states that a resident must have a single room of at least 10 sq m usable space (this takes account of the requirement that they should be able to bring their own personal possessions and furniture within reason). This size was first recommended, it should be remembered, in Building Note 2 published as long ago as 1973. Critics cannot therefore accuse CPA of imposing something above the accepted norm. Furthermore in recommending that new build homes or conversions/extensions and new registrations must have single rooms of 12 sq m, the standards are hardly being revolutionary. A number of other countries in Europe have already moved well above this level.

Following the submission of the standards to the Department of Health and the Welsh Office, they were published as a consultation document-Fit for the Future. Over 8,000 copies were distributed as well as being placed on the Internet-indicating the level of interest in the country. The consultation period proved to be the occasion for considerable lobbying and public debate with many of the independent sector providers voicing criticism - suggesting that the implementation of the standards would put them out of business. A number of surveys were undertaken by different provider organisations seeking to demonstrate what the impact was likely to be. The overall conclusion by most authoritative sources however is that it is very hard to judge the extent of closures that might be forthcoming as a result of implementation. For CPA, it is a matter for regret that there have been many critics of the standards - focusing largely on the issue of room size rather than commending the standards for being realistic, sound and resident-focused.

Now that the Care Standards Bill is before Parliament, the debate has taken off again. The standard have received strong Ministerial backing. In a Parliamentary debate week, critics of the standard - mostly under pressure from care home owners in their constituencies - made their views heard. In reply, Alan Milburn the Secretary of State for Health defended the standards robustly saying 'Good providers have absolutely nothing to fear from the standards that we set out in Fit for the Future. There has been detailed consultation... we shall be sensitive about the way in which we phase in the changes to ensure that the standards can be met. However, ...I would expect the highest possible standards of care for our elderly relatives. There should be no compromise on standards of care. However, the Opposition Front Bench are making the same mistake they made for 18 years. They are more worried about the providers than the users. It is the users of the service who count.'

Conclusion

In any case, whatever standards are laid down, the registered homes sector is increasingly going to be in competition with other forms of care - sheltered housing with extra care, for example, which already provide a more generous size of accommodation. To fight a rearguard battle against the national minimum standards on the basis of room size is shortsighted indeed. Older people will begin to look elsewhere for quality of care and quality of life if the care home sector does not move with the times. If not, it may be heralding its own downfall.

Terms of Reference

The National Council on Ageing and Older People was established on 19 March 1997, in succession to the National Council for the Elderly (January 1990 to March 1997) and the National Council for the Aged (June 1981 to January 1990).

The functions of the Council are as follows

1. *To advise the Minister for Health on all aspects of ageing and the welfare of older people, either at its own initiative or at the request of the Minister and in particular on:*

(a) measures to promote the health of older people;

(b) measures to promote the social inclusion of older people;

(c) the implementation of the recommendations contained in policy reports commissioned by the Minister for Health;

(d) methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for older people;

(e) methods of encouraging greater partnership between statutory and voluntary bodies in providing services for older people;

(f) meeting the needs of the most vulnerable older people;

(g) means of encouraging positive attitudes to life after 65 years and the process of ageing;

(h) means of encouraging greater participation by older people;

(i) whatever action, based on research, is required to plan and develop services for older people.

2. *To assist the development of national and regional policies and strategies designed to produce health gain and social gain for older people by:*

(a) undertaking research on the lifestyle and the needs of older people in Ireland;

(b) identifying and promoting models of good practice in the care of older people and service delivery to them;

(c) providing information and advice based on research findings to those involved in the development and/or implementation of policies and services pertaining to the health, well-being and autonomy of older people;

(d) liaising with statutory, voluntary and professional bodies involved in the development and/or implementation of national and regional policies, which have as their object health gain or social gain for older people.

- *To promote the health, welfare and autonomy of older people.*

- *To promote a better understanding of ageing and older people in Ireland.*

- *To liaise with international bodies which have functions similar to the functions of the Council.*

The Council may also advise other Ministers, at their request, on aspects of ageing and the welfare of older people which are within the functions of the Council.

Membership

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Mr John Cooney	Ms Leonie Lunny
Mr Jim Cousins	Ms Mary McDermott
Mr Joseph Dooley	Dr Diarmuid McLoughlin
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